Coordination of Benefits Form (COB)

Member Name:

Member ID:

Section 1: Member Coverage Information

Are you, your spouse or dependent children covered by any other medical and/or dental coverage?

☐ No, Detego Health	☐ Yes, **other** coverage	☐ Yes, Medicare	☐ Yes, Medicaid or CHAMPUS/VA
(complete section 7)	(complete sections 2-5, 7)	(complete sections 6 and 7)	(complete section 7)

Section 2: Other Coverage Information

Please list all applicable health and/or dental insurance carriers in the space provided. Attach another sheet if needed.

Coverage Company Name:
Coverage Company:
Type of Coverage (select all that apply): ☐ Medical/Physician ☐ Hospital ☐ Prescription Drug ☐ Dental
Type of Enrollment (select one): ☐ Employee ☐ Family ☐ Employee/Spouse ☐ Employee/Child
Other coverage effective date:
Other coverage status (select one): ☐ Active ☐ Reserves ☐ Retiree

Section 3: Policyholder Information for Other Coverage

Policyholder on the policy indicated in section 2:

Last Name:	First Name:
Identification Number (include all letters and numbers):	
Policyholder DOB:	Employer:
Relationship to the policyholder: ☐ Self ☐ Spouse ☐ Dependent ☐ Ex or legally separated spouse ☐ Other	
If relationship is "Self" or "Spouse", indicate employment status: ☐ Actively working with employer offering other coverage ☐ Not actively working / long-term disability	
☐ Retired from employer providing other coverage ☐ COBRA	Retirement date: COBRA effective date:

Section 4: Covered Persons

Complete the following information for all people covered under the other policy. Attach a separate sheet if needed.

Covered person's first and last name	Relationship to the policyholder in section 3 (i.e. self, spouse, child)	DOB mm/dd/yyyy	Mark if covered by Medicare or Medicaid	Mark if dependents are covered under court order
1.			☐	☐
2.			☐	☐
3.			☐	☐
4.			☐	☐
5.			☐	☐
6.			☐	☐

Section 5: Parents That are Divorced, Legally Separated or Never Married

Only complete this section if dependent child(ren) are covered under the policy and the parents are divorced, legally separated or were never married.

If there is a legally binding agreement for health care expenses, who is responsible? Attach a copy of the court order.

☐ Mother ☐ Father ☐ Joint Responsibility ☐ Legal Guardian

If there is no legally binding agreement for health care expenses, who has primary custody?

☐ Mother ☐ Father ☐ Joint Responsibility ☐ Legal Guardian

Section 6: Medicare Enrollee Information

Beneficiary Name	Medicare ID	Employment Status	Coverage Type	Effective Date mm/dd/yyyy	Medicare Entitlement Reason
		☐ Employed ☐ Retired *Date of retirement:* mm/dd/yyyy	☐ Part A ☐ Part B ☐ Part C		☐ Age ☐ Disability ☐ ESRD
		☐ Employed ☐ Retired *Date of retirement:* mm/dd/yyyy	☐ Part A ☐ Part B ☐ Part C		☐ Age ☐ Disability ☐ ESRD

Section 7: Policyholder Signature

Signature:	Date:
Daytime Phone Number:	

Instructions:

Coordination of Benefits (COB) applies when more than one insurance company provides you and/or your family members with health care benefits. COB is applicable to you and all family members that are covered under your current health and/or dental plans.

The following instructions can be used to assist you in filling out the attached COB form. Complete and submit the attached hard copy, which can be mailed or faxed back to us.

Mail:	E-Mail:	Fax:
Detego Health **759 N 114th St. #300** **Omaha, NE 68154**	**COB@detegohealth.com**	**855-613-4102**

SECTION 1: Member Coverage Information

If you or any of your dependents are not covered under another health or dental plan, answer No and skip to Section 7. Please sign and date and provide a daytime phone number so we can contact you if we have any questions. Your form will need to be returned to us at the address or fax number above.

If you or any of your dependents are covered under another health or dental plan, please select Yes to all other answers that apply.

If you answered "Yes, complete Sections 2 – 5, and 7. If you answered "Yes, Medicare," you will need to compete Sections 6 and 7.

If you answered "Yes, Medicaid or CHAMPUS/VA," you only need to complete Section 7.

SECTION 2: Other Coverage Information

You only need to complete this section if you answered **"Yes, other coverage"** in Section 1. Please provide the name and phone number of the other health and/or dental companies that cover you and/ or your dependents. Indicate the type of coverage, type of enrollment and effective date. Please select all that apply to you and your family.

If you have coverage with more than two other companies, please attach a sheet including all the information indicated.

SECTION 3: Policyholder Information of Other Coverage

Complete this section if you answered **"Yes, other coverage"** in Section 1. This information pertains to the additional coverage you or your dependents have with another coverage company (as indicated in Section 2).

Please provide the policyholder's first and last name, identification number of the other coverage company, date of birth, and employer, if applicable. Select the relationship to the policyholder and their employment status.

For example, if your spouse has additional coverage through their employer, your spouse would be the policy holder; their relationship to you would be spouse. In this example, they would mark "Actively working with employer offering other coverage."

SECTION 4: Covered Persons

Complete this section if you answered **"Yes, other coverage"** in Section 1. "Covered persons" refers to all individuals covered under the other plan and your Detego Health plan. Please attach a second sheet if needed.

SECTION 5: Parents that are Divorced, Legally Separated or Never Married
Complete this section if you answered **"Yes, other coverage"** in Section 1. Only complete this section if dependent child(ren) are covered under both your Detego Health policy, the other policy and the parents are divorced, legally separated or never married. Please answer the questions provided on the form and include legal documentation, if applicable, when submitting the COB form.

SECTION 6: Medicare Enrollee Information
Complete this section if you answered **"Yes, Medicare"** in Section 1. The beneficiary, Medicare ID, coverage type and effective date information can be found on your Medicare identification card. Please answer all questions that apply.

SECTION 7: Policyholder Signature
Before submitting, the policyholder must sign, date and provide a valid daytime phone number.